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## Educational and Community Based Programs

### Goal

Increase the quality, availability and effectiveness of educational and community-based programs designed to prevent disease, prevent disability and premature death, and promote the health and quality of life of all Kentuckians (*Healthy People 2010*, 1998).

### Overview

The health of our communities depends in large part on whether the physical and social aspects of the communities make it possible for people to live healthy lives. There is a dynamic and unavoidable interaction between individuals and their environment. While lifestyle choices are ultimately individual choices, these personal decisions are made in the midst of a complex mix of social and community relationships and environments that can actively support or obstruct personal change. Research has shown that behavior change is more likely to happen and be maintained when a person's environment is altered in a manner that supports the change.

This complex of interrelationships between people and their social and community networks is termed "the Socioecological Model". The different levels of the model include: Individual (personal behavior change), Interpersonal and Group (family or peer groups), Institutions and Organizations (such as schools, faith organizations or worksites), Community (local policy makers, planners and civic organizations), and Societal or Public Policy (state or national level policy or law). The most effective community promotion programs are those that take into account the different levels of the Socioecological Model, implementing multiple intervention strategies across multiple settings. For example, community promotion programs that involve educational, policy, and environmental strategies within schools, workplaces, and health care facilities within the community have a greater chance of succeeding. These settings serve as channels for reaching the "targeted" population and, at the same time, generate the possibility of intervening at the policy level to facilitate healthy choices (i.e., smoking cessation classes may lead to a decision for an agency to become "smoke-free").

The school, ranging from preschool through college, provides an important setting for reaching the entire population, over time. Schools have more influence on the lives of youth than any other social institution, except the family. Because healthy children learn better than children with health problems, to achieve their educational mission, schools and colleges must address the health and related social problems of youth. A focal point of their efforts, in this respect, must be to reduce health risks and improve the health status of youth.

The growing cost of health care coupled with the increasing problems of preventable acute and chronic illness have brought health education to the forefront of workplace concerns. Health promotion in the workplace is critical to the long-term maintenance of our nation's health. Increasing awareness, promoting healthy individual lifestyles, fostering health-related behavior changes and creating supportive work environments are core to workplace health promotion. This, in turn, is beneficial to managers, employees, and the community at large.

## Summary of Progress

Progress has been made in several areas of educational and community based programs. The high school dropout rate has actually been reduced, which means that more Kentucky citizens are in a position to hold better jobs, earn a better income, and are more likely to have health insurance. Progress has been made in school health programs. The decrease in the ratio of students to school nurses, and the implementation of a coordinated school health program statewide will impact policies and programs in all Kentucky schools. In community health programming, local health departments are offering more and more programs to Kentucky citizens which address multiple *Healthy Kentuckians 2010* objectives. They are also offering culturally appropriate programming to meet the needs of different social and ethnic groups as well as serving more older citizens than ever before.

## Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Educational and Community Based Programs	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
4.1. Increase to at least 90 percent the number of individuals, through age 24, who have completed high school.	74.7% (2000)	≥90%	74.7% (2000)	N/A	Census
4.2. Reduce the annual dropout rate for students enrolled in grades 9-12, to a rate of less than 5 percent.	5.2% (1997)	<5%	3.4% (2004)	Target Achieved	KY Dept. of Education
4.3. (DELETED)					
4.4R. Increase to or maintain at 95 percent the proportion of public middle and high schools that require instruction in the areas that contribute to the leading causes of morbidity and mortality among youth.	See Below (2002)	Increase to or Maintain at 95%	See Below (2002)		
<u>2002 Baseline Middle School</u>	%	%	%	N/A	SHEP
HIV Prevention	97.3	95	97.3		
Sexually Transmitted Diseases	94.7	95	94.7		
Human Sexuality	77.6	95	77.6		
Accident or Injury Prevention	93.4	95	93.4		
Alcohol or Other Drug Prevention	97.4	95	97.4		
Suicide Prevention	66.7	95	66.7		
Tobacco Use Prevention	98.7	95	98.7		
Violence Prevention	85.5	95	85.5		
Benefits of Healthy Eating	100	95	100		
Risks of Unhealthy Weight Control	96.0	95	96.0		
Accepting Body Size Differences	89.3	95	89.3		
Decreasing Sedentary Activity	89.2	95	89.2		

R = Revised objective

N/A = Only baseline data are available. Not able to determine progress at this time.

## Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Educational and Community Based Programs	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
<u>2002 Baseline High School</u>	% (2002)	%	% (2002)	N/A	SHEP
HIV Prevention	98.2	95	98.2		
Sexually Transmitted Diseases	98.2	95	98.2		
Human Sexuality	92.0	95	92.0		
Accident or Injury Prevention	96.4	95	96.4		
Alcohol or Other Drug Prevention	98.2	95	98.2		
Suicide Prevention	83.6	95	83.6		
Tobacco Use Prevention	98.2	95	98.2		
Violence Prevention	90.1	95	90.1		
Benefits of Healthy Eating	98.2	95	98.2		
Risks of Unhealthy Weight Control	97.3	95	97.3		
Accepting Body Size Differences	95.5	95	95.5		
Decreasing Sedentary Activity	93.6	95	93.6		
4.5. - 4.6. (DELETED)					
4.7. Increase the nurse to student ratio to 1:750 among Kentucky's elementary, middle, and junior high schools.	1:1831.25 (1997-98)	1:750	1:1426 (2004-05)	Yes	Ky Dept. of Education
4.8. (Developmental) Increase to at least 50 percent of worksites in Kentucky that offer a health promotion activity, preferably as part of a comprehensive worksite health promotion program.	39% (2001)	≥50%	39% (2001)	N/A	CHWS
4.9. (Developmental) Increase to at least 37 percent the number of employees who participate in one or more "employer-sponsored" health promotion activities.	23% (2001)	≥37%	23% (2001)	N/A	CHWS

N/A = Only baseline data are available. Not able to determine progress at this time.

## Progress toward Achieving Each HK 2010 Objective

Summary of Objectives for Educational and Community Based Programs	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
4.10.- 4.12. (DELETED)					
4.13. Maintain the annual operating standard of 100 percent of Local Health Departments that submit a community health promotion plan that addresses multiple <i>Healthy People 2010</i> focus areas.	100% (1999)	100%	100% (2005)	Target Achieved	Activity Plans of LHDs
4.14. (Developmental) Increase by 50 percent the proportion of Local Health Departments (LHDs) that have established culturally appropriate and linguistically competent community health promotion and disease prevention programs for racial and ethnic minority populations.	5 LHDs reported providing 27 activities to 615 participants (FY 2002)	≥8 LHDs	6 LHDs reported providing 19 activities to 2,176 participants (FY 2003)	Yes	Activity Plans of LHDs
4.15. (Developmental) Increase by 25 percent the proportion of people age 65 and older that have participated during the preceding year in at least one organized health promotion program.	30,544 65 and older participants via LHD programs (FY 2003)-	≥38,180	49,872 65 and older participants via LHD programs (FY 2004)	Target Achieved	Community Based Planning Data Warehouse